FOR OHF USE

LL1

2002

STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 004 Facility Name: ANNA HENRY NSG & R	1483 EHAB CTR		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER					
	Address: 637 HILLSBORO AVENUE Number County: MADISON Telephone Number: (618) 656-1136	EDWARDSVILLE City Fax # (618) 656-1190	62025 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information						
	IDPA ID Number: 364054689001 Date of Initial License for Current Owners: Type of Ownership:	10/01/95		in this o	(Signed) (Date) (Type or Print Name)					
	VOLUNTARY, NON-PROFIT Charitable Corp. Trust IRS Exemption Code	X PROPRIETARY Individual Partnership Corporation	GOVERNMENTAL State County Other	of Frovider	(Signed) See Accountants' Compilation Report Attached (Date)					
		"Sub-S" Corp. X Limited Liability Co. Trust Other		Paid Preparer	(Print Name and Title) (Firm Name Frost, Ruttenberg & Rothblatt, P.C.					
	In the event there are further questions about Name: Steve Lavenda	this report, please contact: Telephone Number: (847) 236		& Address) 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax # (847) 236-1155 MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630						

STATE OF ILLINOIS Page 2

Facil	lity Name & ID Numb	oer <u>ANNA HE</u> NI	RY NSG & REHAB	CTR			# 0041483 Report Period Beginning: 01/01/02 Ending: 12/31/02
	III. STATISTICA	L DATA			D. How many bed-hold days during this year were paid by Public Aid?		
	A. Licensure/	certification level(s) of	f care; enter number	r of beds/bed days,	NONE (Do not include bed-hold days in Section B.)		
		with license). Date of		• /			<u> </u>
	(g	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	1		(E.g., day care, "meals on wheels", outpatient therapy)
	<u> </u>	<u>4</u>		<u></u>			200
	D. J 4				T		<u>N/A</u>
	Beds at	τ.			Licensed		
	Beginning of	Licensu	-	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? YES
	Report Period	Level of	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1	58		/	58	1	investments not directly related to patient care?	
		Skilled Pedi	atric (SNF/PED)		2	YES NO X	
3	56	Intermediat	e (ICF)	56	3		
4		Intermediat	e/DD		4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?	
							YES NO X
6		ICF/DD 16	or Less			6	
						I. On what date did you start providing long term care at this location?	
7	114	TOTALS		114	7	Date started <u>01/01/96</u>	
					J. Was the facility purchased or leased after January 1, 1978?		
	B. Census-For	r the entire report per	riod.				YES X Date 02/21/96 NO
	1	2	3	4	5		<u> </u>
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES X NO If YES, enter number
		Recipient	Private Pav	Other	Total		of beds certified 14 and days of care provided 506
8	56 Intermediate (ICF) Intermediate/DD Sheltered Care (SC) ICF/DD 16 or Less 114 TOTALS B. Census-For the entire report period. 1 2 3 Level of Care Patient Days by Level of C Public Aid Recipient Private P SNF SNF/PED ICF 17,349 2 ICF/DD SC DD 16 OR LESS				2,873	8	
				550	2,0.0	9	Medicare Intermediary TRISPAN
		17.349	2.423	1.220	20.992	10	
		17,017	2,120	1,220	20,552	11	IV. ACCOUNTING BASIS
	Skilled Pediatric (SNF/PED)						MODIFIED
						12	ACCRUAL X CASH* CASH*
15	DD 10 OK EESS					13	Reckonii A Chon
14	TOTALS	19,716	2,423	1,726	23,865	14	Is your fiscal year identical to your tax year? YES X NO
		,	,	, -	, , ,		
				otal licensed			Tax Year: 12/31/02 Fiscal Year: 12/31/02
	bed days or	n line 7, column 4.)	57.35%	_	CEE ACCOUNTS AN	ATTECL CO	* All facilities other than governmental must report on the accrual basis.
					SEE ACCOUNTAI	A12, CC	OMPILATION REPORT

Page 3 12/31/02 STATE OF ILLINOIS Facility Name & ID Number ANNA HENRY NSG & REHAB CTR 0041483 **Report Period Beginning:** 01/01/02 **Ending:**

	V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) Costs Per General Ledger Reclassified Adjust- Adjusted FOR OHF USE ONLY												
						Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY		
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total				
	A. General Services	1	2	3	4	5	6	7	8	9	10		
1	Dietary	112,178	11,574	4,358	128,110		128,110		128,110			1	
2	Food Purchase		158,132		158,132	(9,822)	148,310	(161)	148,149			2	
3	Housekeeping	41,824	13,651		55,475		55,475		55,475			3	
4	Laundry	51,526	4,906		56,432		56,432		56,432			4	
5	Heat and Other Utilities			101,726	101,726		101,726		101,726			5	
6	Maintenance	33,293	7,166	35,867	76,326		76,326	(9,143)	67,183			6	
7	Other (specify):*											7	
8	TOTAL General Services	238,821	195,429	141,951	576,201	(9,822)	566,379	(9,304)	557,075			8	
	B. Health Care and Programs												
9	Medical Director			7,650	7,650		7,650	(2,700)	4,950			9	
10	Nursing and Medical Records	813,748	52,637	19,108	885,493		885,493	5,246	890,739			10	
10a	Therapy			10,557	10,557		10,557		10,557			10a	
11	Activities	37,798	427	2,579	40,804		40,804		40,804			11	
12	Social Services	35,317		4,825	40,142		40,142		40,142			12	
13	Nurse Aide Training											13	
14	Program Transportation			3,512	3,512		3,512		3,512			14	
15	Other (specify):*							1,219	1,219			15	
16	TOTAL Health Care and Programs	886,863	53,064	48,231	988,158		988,158	3,765	991,923			16	
	C. General Administration												
17	Administrative	55,877		274,000	329,877		329,877	(156,780)	173,097			17	
18	Directors Fees											18	
19	Professional Services			47,870	47,870		47,870	2,687	50,557			19	
20	Dues, Fees, Subscriptions & Promotions			21,659	21,659		21,659	(3,483)	18,176			20	
21	Clerical & General Office Expenses	56,741	18,394	25,141	100,276		100,276	15,410	115,686			21	
22	Employee Benefits & Payroll Taxes			210,967	210,967	9,822	220,789		220,789			22	
23	Inservice Training & Education											23	
24	Travel and Seminar			1,587	1,587		1,587	285	1,872			24	
25	Other Admin. Staff Transportation			1,999	1,999		1,999	2,474	4,473			25	
26	Insurance-Prop.Liab.Malpractice			144,364	144,364		144,364	208	144,572			26	
27				·	·			8,248	8,248			27	
28	TOTAL General Administration	112,618	18,394	727,587	858,599	9,822	868,421	(130,951)	737,470			28	
20	TOTAL Operating Expense	1 229 202	266,887	017.760	2 422 059		2 422 059	(136 490)	2 296 460			29	
29	(sum of lines 8, 16 & 28)	1,238,302		917,769	2,422,958		2,422,958 SEE ACCOUNT	(136,489)	2,286,469	T		29	

SEE ACCOUNTANTS' COMPILATION REPORT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

			Cost Per General Ledger Re				Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage			Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,399	11,399		11,399	110,171	121,570			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,354	29,354		29,354	74,190	103,544			32
33	Real Estate Taxes			22,320	22,320		22,320	(824)	21,496			33
34	Rent-Facility & Grounds			129,917	129,917		129,917	(103,031)	26,886			34
35	Rent-Equipment & Vehicles			9,247	9,247		9,247	1,750	10,997			35
36	Other (specify):*							7,516	7,516			36
37	TOTAL Ownership			202,237	202,237		202,237	89,772	292,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,496	41,644	50,140		50,140	(6,343)	43,797			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,415	62,415		62,415		62,415			42
43	Other (specify):*			1,791	1,791		1,791	(1,791)	0			43
44	TOTAL Special Cost Centers		8,496	105,850	114,346		114,346	(8,134)	106,212			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,238,302	275,383	1,225,856	2,739,541		2,739,541	(54,851)	2,684,690			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

0041483

Report Period Beginning:

01/01/02

Ending: 12/

12/31/02

VI. ADJUSTMENT DETAIL A. The expenses indicate

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column	1 2 below,	reference the f	ine on wi	nich the particula	ar cosi
			1	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		24,086	30		9
10	Interest and Other Investment Income		(13)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(161)	02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(543)	21		18
19	Entertainment		(1,045)	20		19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional		(994)	20		25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees		/4 / / **	20		27
28	Yellow Page Advertising		(1,603)	20		28
29	Other-Attach Schedule		(35,983)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(16,255)		\$	30

B. If there are expenses experienced by the facility which do not appear in th	e
general ledger, they should be entered below. (See instructions.)	

			1	Z	
		A	mount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		(38,596)		34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	(38,596)		36
	(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$	(54,851)		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

	OHF USE ONL	Y				
48		49	50	51	52	

	NON-ALLOWABLE EXPENSES	Amount	Reference	
	BAD DEBT	S (9,454)	Reference 21	1
	MARKETING	(1,791)	43	2
3 F	RANCHISE TAX	(335)	21	3
4 N	AISC. INCOME	(20)	21	4
5 E	BANK CHARGE TNANCE CHARGE	(2,726) 1,960	21 32	5
6 F	INANCE CHARGE BANK CHARGE-BUILDING	1,960	21	2
	REAL ESTATE TAX PENALTIES	(835)	33	8
9 P	PA-INTEREST	(4,448)	32	5
10 P	PA-MEDICAL DIRECTOR	(2,700)	09	1
11 P	PA-OT	(2,933)	39	1
12 P	PA-PT	(1,811)	39	1
13 P	PA-ST	(1,599)	39	1.
14 B	t & M	(9,143)	06	1
15				1:
16				10
17 18				11
19				1
20				2)
21				2
22				2:
23				2.
24				2
25		1		2:
26		1		2
27 28				2
28		1		25
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98 99		1		9:
"				16
100				

STATE OF ILLINOIS

Summary A Facility Name & ID Number ANNA HENRY NSG & REHAB CTR **# 0041483 Report Period Beginning:** 01/01/02 **Ending:** 12/31/02 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	SUMMART OF TAGES 5, 5A, 0, 0A												SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6Н	6 I	(to Sch V, col.	.7)
1	Dietary													1
2	Food Purchase	(161)											(161)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(9,143)											(9,143)	6
7	Other (specify):*													7
8	TOTAL General Services	(9,304)											(9,304)	8
	B. Health Care and Programs													
9	Medical Director	(2,700)											(2,700)	9
10	Nursing and Medical Records			5,246									5,246	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			1,219									1,219	15
16	TOTAL Health Care and Programs	(2,700)		6,465									3,765	16
	C. General Administration													
17	Administrative			(156,780)									(156,780)	
18	Directors Fees													18
19	Professional Services			2,687									2,687	19
20	Fees, Subscriptions & Promotions	(3,642)		159										
21	Clerical & General Office Expenses	(13,226)	148	28,488									15,410	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			285										24
25	Other Admin. Staff Transportation			2,474										25
26	Insurance-Prop.Liab.Malpractice			208										26
27	Other (specify):*			8,248									8,248	27
28	TOTAL General Administration	(16,868)	148	(114,231)									(130,951)	28
	TOTAL Operating Expense													1
29	(sum of lines 8,16 & 28)	(28,871)	148	(107,766)									(136,489)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6 I	(to Sch V, col	.7)
30	Depreciation	24,086	85,661	424									110,171	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,501)	76,444	247									74,190	32
33	Real Estate Taxes	(835)		11									(824)	33
34	Rent-Facility & Grounds		(107,460)	4,429									(103,031)	34
35	Rent-Equipment & Vehicles			1,750									1,750	35
36	Other (specify):*		7,516										7,516	36
37	TOTAL Ownership	20,750	62,161	6,861									89,772	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(6,343)											(6,343)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,791)											(1,791)	43
44	TOTAL Special Cost Centers	(8,134)											(8,134)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(16,255)	62,309	(100,905)									(54,851)	45

0041483

Report Period Beginning:

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1			2		3			
OWNE	RS	RELATED N	OTHER R	ELATED BUSINESS ENT	ITIES			
Name	Ownership %	Name	City	Name	Name City			
SEE ATTACH		SEE ATTACH						
				SEE ATTACH				
				EDWARDSVILLE	EDWARDSVILLE HC			
				PROPERTIES	EDWARDSVILLE	PARTNERSHIP		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth. NO

ANNA HENRY NSG & REHAB CTR

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-			Percent	Operating Cost	Adjustments for	
Sc	hedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	34	RENT	\$ 107,460	EDWARDSVILLE HEALTHCARE PROPERTIES		\$	\$ (107,460)	1
2	V	36	AMORT.LOAN		EDWARDSVILLE HEALTHCARE PROPERTIES		7,516	7,516	2
3	V		BANK CHARGES		EDWARDSVILLE HEALTHCARE PROPERTIES		148	148	3
4	V		DEPRECIATION		EDWARDSVILLE HEALTHCARE PROPERTIES		85,661	85,661	4
5	V	32	INTEREST-MORTGAGE		EDWARDSVILLE HEALTHCARE PROPERTIES		76,444	76,444	5
6	V								6
7	V								7
8	V								8
9	V								9
10) V								10
1	l V								11
12	2 V								12
1.	V								13
14	4 Total			\$ 107,460			\$ 169,769	\$ * 62,309	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

#

0041483

Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ı
					ě	Ownership	Organization	Costs (7 minus 4)	
15	V	10	NURSE CONSULTANT	\$	HEALTHCARE MNGMNT. ASSOC.	100.00%			15
16	V		HEALTH CARE EMPLOYEE BENEFI	ITS	HEALTHCARE MNGMNT. ASSOC.	100.00%	1,219	1,219	16
17	V	17	ADMIN. SALNON OWNER		HEALTHCARE MNGMNT. ASSOC.	100.00%	19,327	19,327	17
18	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,687	2,687	18
19	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	159	159	19
20	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	23,839	23,839	20
21	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	285	285	21
22	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,474	2,474	22
23	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	208	208	23
24	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,251		
25	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	424	424	25
26	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	4,429	4,429	26
27	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	247	247	27
28	V	33	REAL ESTATE TAXES		HEALTHCARE MNGMNT. ASSOC.	100.00%	11	11	28
29	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,750	1,750	29
30	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	4,649	4,649	30
31	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	515	515	31
32	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%			32
33	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%			33
34	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	6,256	6,256	34
35	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	7,637	,	35
36	V		EMP. BENM. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	624		36
37	V		EMP. BEND. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	858		
38	V	17	MANAGEMENT FEE	190,000	HEALTHCARE MNGMNT. ASSOC.	100.00%		(190,000)	38
39	Total			\$ 190,000			\$ 89,095	\$ * (100,905)	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6B

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-			Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n l
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V		<u> </u>				<u> </u>		36
37	V		•				<u> </u>		37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6C Ending:

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VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6D **Ending:** 12/31/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
					m vi vi vi vi vi gi vi vi vi	Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whership	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6F **Ending:** 12/31/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		•	\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6G **Ending:**

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VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ated organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
1.5 6 2.2						Ownership	Organization	Costs (7 minus 4)	_
15	V			\$		O WHEISHIP	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6H Ending:

12/31/02

VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizat	ions?	This includes ren
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

_	the msu t		or determining costs as specified for	ı	T	1	ı	ı	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	,
2011		2,110	200	12	Time of Itemore organization	Ownership	Organization	Costs (7 minus 4)	_
15	V			S		Ownership	S Organization	costs (7 mmus 4)	15
16	V			3			3	3	16
17	V	-				+			17
18	V	-				+			18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
	Total			e			c	\$ *	39
39	Total			Þ			Þ	Φ	37

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions wit	h rela		
	management fees, purchase of supplies, and so forth.		YES	NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	ո
					m vi vi vi vi vi gi vi vi vi	Ownership	Organization	Costs (7 minus 4)	
15	V			\$		o whership	\$	\$	15
16	V			-			-	-7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	rs Per Work				ı
					Compensation	Week Devo	oted to this	Compensation	on Included	Schedule V.	ı
					Received	Facility and	% of Total	in Costs	for this	Line &	I
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	İ
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	I
1	ERIC ROTHNER	RELATIVE	ADMIN	0	SEE ATTACHED	0.42	0.59%	MGT FEES	\$ 38,640	17-3	1
2	DAVID ARYEH	OWNER	ADMIN	5.26%	SEE ATTACHED	4.99	6.93%	MGT FEES	6,720	17-3	2
3	DAVID ARYEH	OWNER	ADMIN	5.26%	SEE ATTACHED	4.99	6.93%	ALLOC. HMA	7,637	17-7	3
4	MARK SUISSA	OWNER	ADMIN	42.98%	SEE ATTACHED	8.09	13.49%	MGT FEES	38,640	17-3	4
5	MARK SUISSA	OWNER	ADMIN	42.98%	SEE ATTACHED	8.09	13.49%	ALLOC. HMA	6,256	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 97,893		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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VIII. ALLOCATION OF INDIRECT COSTS	

A. Are there any costs included in this report which were	derived from allocations of central office	
or parent organization costs? (See instructions.)	YES NO	

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number

Fax Number

()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
Referen	ce Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1 Keieren	Ttem	Square Feet)	Total Ullits	Anocated Among	Anocateu	© III COIUIIIII O		\$	1
2					J)	J)		D	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18 19									18 19
20									20
21									20 21
22									22
23									22 23
24									24
25 TOTALS					\$	\$		S	25

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

Street Address City / State / Zip Code Phone Number

Name of Related Organization

HEALTHCARE MNGMNT. ASSOC. 1401 S. BRENTWOOD BOULEVARD

BRENTWOOD, MO. 63144

314) 963-7570

314) 963-9030 Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	10	NURSE CONSULTANT	ILL. & MO. PAT. DAYS	291,047	6	\$ 63,981	\$ 63,981	23,865	\$ 5,246	1
2	15	HEALTH CARE EMPLOYEE BI	ILL. & MO. PAT. DAYS	291,047	6	14,862		23,865	1,219	2
3	17	ADMIN. SALNON OWNER	ILL. & MO. PAT. DAYS	291,047	6	235,701	235,701	23,865	19,327	3
4	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	291,047	6	32,764		23,865	2,687	4
5	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	291,047	6	1,941		23,865	159	5
6	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	291,047	6	290,735	211,448	23,865	23,839	6
7	24	SEMINAR	ILL. & MO. PAT. DAYS	291,047	6	3,475		23,865	285	7
8	25	TRAVEL	ILL. & MO. PAT. DAYS	291,047	6	30,170		23,865	2,474	8
9	26	INSURANCE	ILL. & MO. PAT. DAYS	291,047	6	2,542		23,865	208	9
10	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	291,047	6	76,229		23,865	6,251	10
11	30	DEPRECIATION	ILL. & MO. PAT. DAYS	291,047	6	5,169		23,865	424	11
12	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	291,047	6	54,010		23,865	4,429	12
13	32	INTEREST	ILL. & MO. PAT. DAYS	291,047	6	3,011		23,865	247	13
14	33	REAL ESTATE TAXES	ILL. & MO. PAT. DAYS	291,047	6	131		23,865	11	14
15	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	291,047	6	21,338	34,464	23,865	1,750	15
16	21	CLERICAL SALARIES	ILL. PAT. DAYS	176,918	4	34,464		23,865	4,649	16
17	27	EMP. BEN. GEN. & ADMIN.	ILL. PAT. DAYS	176,918	4	3,816		23,865	515	17
18		CLERICAL SALARIES	DIRECT		1	24,711	24,711			18
19	27	EMPLOYEE BENEFITS	DIRECT		1	2,776				19
20	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED		6	46,381	46,381	8	6,256	20
21	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED		4	56,621	56,621	5	7,637	21
22		EMP. BENM. SUISSA	AVG. HOURS WORKED		6	4,626		8	624	22
23	27	EMP. BEND. ARYEH	AVG. HOURS WORKED	37	4	6,361		5	858	23
24										24
25	TOTALS					\$ 1,015,815	\$ 673,306		\$ 89,095	25

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	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		3	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16 17										16
										17
18 19										18 19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					s	s		c	_
25	IUIALS					Þ	Э		D	25

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Ending: 12/31/02

VIII	ALL	OCATION	OF INDIRECT	COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9 10
10 11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization
A. Are there any costs included in this report which were derived from allocations of central office	Street Address
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code
	Phone Number ()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	110101 CHCC	Ttom	Square reet)	10tal Chits	Timocarca Timong	S	\$	Cints	\$	1
2							4		-	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20 21
21										21
22										22 23
23										
24										24
25	TOTALS					\$	\$		\$	25

#	0	04	1	483

01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
14										15
15 16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		S	25

01/01/02

Ending: 12/31/02

VIII	ALI	OCATI	ON OF	INDIRECT	COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		Ŭ	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12 13
13 14										13
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					\$	\$		\$	25

#	004	1483

01/01/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
14										15
15 16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
	TOTALS					s	\$		S	25

#	0041483
π	UUTITUU

01/01/02

Ending: 12/31/02

VIII	ALI	OCATION	OF INDIRECT	COSTS
V 111.	ALL	OCALION	OF INDINECT	COSIS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
	Phone Number	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9 10
10 11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

0041483 Report Period Beginning:

01/01/02 **Ending:** 12/31/02

•	III. ALLOCATION OF INDIRECT COSTS	

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
21 22 23 24										22
23										23
										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	6	7	8	9	10	
	Name of Lender	Relate YES	ed** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amou Original	ınt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related				•		<u> </u>			, ,		
	Long-Term											
1	CIB		X	MORTGAGE		06/01/02	\$ 1,200,000	\$ 885,081	11/30/003		\$ 76,444	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CORUS BANK			LINE OF CREDIT		06/01/02		197,982			16,485	6
7	ASSURANCE		X	INSURANCE FINANCING							5,143	7
8	CANAWILL		X	INSURANCE FINANCING							789	8
9	TOTAL Facility Related						\$ 1,200,000	\$ 1,083,063			\$ 98,862	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,682	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 4,682	14
15	TOTALS (line 9+line14)						\$ 1,200,000	\$ 1,083,063			\$ 103,544	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number

ANNA HENRY NSG & REHAB CTR

0041483

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender			Purpose of Loan	Monthly Payment	Date of		int of Note	Maturity Date	Interest Rate	Reporting Period Interest	
1	Interest Income	YES X	NO		Required	Note	Original \$	Balance \$		(4 Digits)	Expense (13)	1
	Grand Manor	X					Ф	D			4,448	_
_	Alloc. Hma	X									247	3
4	Anoc. Iiiia	Λ									247	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ 4,682	21

STATE OF ILLINOIS

Page 10 12/31/02 # 0041483 Report Period Beginning: **01/01/02** Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) **B. Real Estate Taxes**

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR

	Important , please see the next worksheet	, "RE Tax". The real	estate tax statement and			
1. Real Estate Tax accrual used on 2001 report.	bill must accompany the cost report.	· <u>-</u>		\$	23,500	1
2. Real Estate Taxes paid during the year: (Indicate th	ne tax year to which this payment applies. If payment cov	rers more than one year, do	etail below.)	\$	21,996	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,504)	3
4. Real Estate Tax accrual used for 2002 report. (Det	ail and explain your calculation of this accrual on the line	es below.)		\$	23,000	4
**	has NOT been included in professional fees or other gen pies of invoices to support the cost and a co			\$		5
6. Subtract a refund of real estate taxes. You must of classified as a real estate tax cost plus one-half of a TOTAL REFUND \$ For		eal estate tax appeal	board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, l	ine 33. This should be a combination of lines 3 thru 6.			\$	21,496	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	997 21,632 8		FOR OHF USE ONLY			,
19	298 22,346 9 299 22,729 10	13	FROM R. E. TAX STATEMENT	FOR 2001 \$		13
20	$ \begin{array}{c cccc} 000 & 20,656 & 11 \\ 001 & 21,985 & 12 \end{array} $	14	PLUS APPEAL COST FROM LII	NE 5 \$		14
2002 TAX ACCRUAL 21,982 *1.05=23,081 ALLOCATION FROM HMA \$11		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR PATE (16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

	R.				C	
Р						

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

	THE PROPERTY OF THE PROPERTY O		STATE	VII. 1 I	
ANNA HENRY	NSG & REHAB CTR		COUNTY	MADISON	
ENSE NUMBER	0041483				
REGARDING TH	IS REPORT STEVE LAVENDA				
236-1111	FAX #: (8-	47)236-1	155		
to the operation of which is vacant, ren	the nursing home in Column D. Real ted to other organizations, or used for	l estate ta purposes	x applicable s other than le	to any portion	of the nursin
A)	(B)		(C)	A	(D) <u>Tax</u> Applicable to
Number	Property Description		Total Tax		ursing Home
03-014	LONG TERM CARE PROPERTY	_			21,985.21
FROM HMA		\$		_ \$	11.00
		\$		_ \$	
		S_		_	
	TOTALS	\$	21,985.21	_ s	21,996.21
			perty, or prop	erty which is 1	not directly
	ENSE NUMBER REGARDING TH 236-1111 eal Estate Tax Context in the operation of which is vacant, ren in D. Do not included in the operation of the context in the operation of the warm of the context in t	REGARDING THIS REPORT STEVE LAVENDA 236-1111 FAX #: (8 2al Estate Tax Cost lex number and real estate tax assessed for 2001 on the li to the operation of the nursing home in Column D. Real which is vacant, rented to other organizations, or used for nn D. Do not include cost for any period other than cale (a) (B) ENUMBER Property Description LONG TERM CARE PROPERTY FROM HMA TOTALS (Cost Allocations n of the tax bill apply to more than one nursing home, va	REGARDING THIS REPORT STEVE LAVENDA 236-1111 FAX #: (847)236-1 247-121 FAX #: (847)236-1 24	REGARDING THIS REPORT STEVE LAVENDA 236-1111 FAX #: (847)236-1155 Leal Estate Tax Cost Lex number and real estate tax assessed for 2001 on the lines provided below. It to the operation of the nursing home in Column D. Real estate tax applicable which is vacant, rented to other organizations, or used for purposes other than length of the nursing home in Column D. Do not include cost for any period other than calendar year 2001. (C) Number Property Description Total Tax	REGARDING THIS REPORT STEVE LAVENDA 236-1111 FAX #: (847)236-1155 exal Estate Tax Cost lex number and real estate tax assessed for 2001 on the lines provided below. Enter only the to the operation of the nursing home in Column D. Real estate tax applicable to any portion which is vacant, rented to other organizations, or used for purposes other than long term care on D. Do not include cost for any period other than calendar year 2001. (B) (C) Number Property Description Total Tax Number Number

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which

C. Tax Bills

is normally paid during 2002.

10.0	\mathbf{n}	nт		TΝ	$^{\sim}$	101
IIVI	PU	ĸı.	AΝ	ΙN	υı	IUI

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

	2000 LONG TE	ERM CARE REAL ESTATI	E TAX STATE	MENT
FAC	ILITY NAME ANNA HENRY	7 NSG & REHAB CTR	COUNTY	MADISON
FAC	ILITY IDPH LICENSE NUMBER	0041483		
CON	TACT PERSON REGARDING TH	HIS REPORT		
		FAX #: (
Α.	Summary of Real Estate Tax Co			
	cost that applies to the operation of home property which is vacant, ret	al estate tax assessed for 2000 on the lir f the nursing home in Column D. Real nted to other organizations, or used for ude cost for any period other than calen	estate tax applicable purposes other than le	to any portion of the nursing
	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	<u>Total Tax</u>	Tax Applicable to Nursing Home
1.			\$	
2.			\$	
3.			\$	
4.			\$	
5.			\$	
6.			\$	
7.			s	
8.			s	
9.			\$	
10.			\$	\$
		TOTALS	\$	<u> </u>
В.	Real Estate Tax Cost Allocations	S		
	Does any portion of the tax bill appused for nursing home services? If YES, attach an explanation & a	ply to more than one nursing home, vac YES NO schedule which shows the calculation of	of the cost allocated to	o the nursing home.
C.	Tax Bills	must be another to the narsing nome t	abea upon sq. 1t. 01 s	pare asea.)
C.				
	Attach a copy of the 2000 tax bills is normally paid during 2001.	which were listed in Section A to this	statement. Be sure to	use the 2000 tax bill which

Facil	ity Name & ID Number ANNA HENR	Y NSG & REHAB CTR		# 0041483	Report Po	eriod Beginning:		01/01/02 Ending:	12/31/02
X. BU	UILDING AND GENERAL INFORMA	ATION:						-	
A.	Square Feet: 26,542	B. General Construction Type:	Exterior	MASONRY	Frame	STEEL		Number of Stories	1
C.	Does the Operating Entity?	(a) Own the Facility	X (b) Rent from	a Related Organization	n.			Rent from Completely Uni Organization.	related
	(Facilities checking (a) or (b) must co	omplete Schedule XI. Those checking (c)	may complete Schedul	le XI or Schedule XII-A	. See instru	ctions.)		-	
D.	Does the Operating Entity?	X (a) Own the Equipment	X (b) Rent equip	oment from a Related C	Organization	•	X (c)	Rent equipment from Com Unrelated Organization.	ıpletely
	(Facilities checking (a) or (b) must co	omplete Schedule XI-C. Those checking (c) may complete Scheo	dule XI-C or Schedule X	XII-B. See ir	structions.)		S	
Е.	(such as, but not limited to, apartmer	by this operating entity or related to the nts, assisted living facilities, day training uare footage, and number of beds/units a	facilities, day care, inc	lependent living facilitic					
F.	Does this cost report reflect any orga If so, please complete the following:	nization or pre-operating costs which are	e being amortized?			YES	X	NO	
1.	. Total Amount Incurred:			2. Number of Years C	Over Which	it is Being Amort	tized:		
3.	. Current Period Amortization:			4. Dates Incurred:					
		Nature of Costs: (Attach a complete schedule detail	iling the total amount	of organization and pre	e-operating	costs.)			
XI. C	OWNERSHIP COSTS:								
		1	2	3		4			
	A. Land.	Use	Square Feet	Year Acquired		Cost			
		1 FACILITY		199	0 2	137,273	1 2		
		3 TOTALS			\$	137,273	3		

STATE OF ILLINOIS

Page 11

0041483

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	D. Dullul	ing Depreciation-Including Fixed Equ	1 7	1 3	4	1 5	6	7	8	9	_
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line	o	Accumulated	
	Beds*	FOR OHF USE ONL!	Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
L.,	Deus"		Acquireu	Constructed	Cost	Depreciation	m rears	Depreciation	•	Depreciation	+
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**	_			•					
9	Various			1996	29,319		20	1,465	1,465	10,235	9
10	Various			1997	57,882		20	2,896	2,896	15,607	10
11	Various			1998	34,159		20	1,707	1,707	7,555	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		s -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		=	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48 49					-		-	48 49
50					-		-	50
51					-		<u> </u>	51
52								52
53					_		_	53
54					_		_	54
55					_		_	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
		2,209,643	56,658		73,655	16,997	515,585	67
68 Related Party Allocations (Page 12-REP & Page 12A-REP) 69 Financial Statement Depreciation		2,207,043	3,354		13,033	(3,354)	313,303	69
69 Financial Statement Depreciation 70 TOTAL (lines 4 thru 69)		\$ 2,331,003	\$ 60,012		\$ 79,723	\$ 19,711	\$ 548,982	70
/U 1 O 1 AL (IIIICS 4 IIII U U7)		پ <u>2,331,003</u>	φ 00,012		v 19,143	φ 19,/11	J40,902	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment.	. (See instructions.) Rou		5	6	7	8	0	
1	Year	T	Current Book	Life	Straight Line	0	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,331,003	\$ 60,012	111 1 041 5	\$ 79,723	\$ 19,711	\$ 548,982	1
2 PIPING FOR BOILER	1999	3,220	\$ 00,012	20	161	161	604	2
3 PIPING PROJECT	1999	4,655		20	233	233	874	3
4 PIPING	1999	599		20	30	30	110	4
5 BOILER REPAIRS	1999	646		20	32	32	125	5
6 FLOOR TILE	1999	500		20	25	25	79	6
7 FLOOR TILE	2000	606		20	30	30	60	$\frac{1}{7}$
8 A/C COMPRESSOR	2000	985		20	49	49	98	8
9 SEWER LINE REPLACEMN	2000	2,579		20	129	129	258	9
10 PAINTING & DECORATIN	2000	564		20	28	28	56	10
11 PAINTING & DECORATIN	2000	719		20	36	36	72	11
12 AIR CONDITIONERS	2000	3,859		20	193	193	386	12
13 PLUMBING REPAIRS	2001	3,731		20	187	187	234	13
14 WASHER ROOM REPAIRS	2001	1,908		20	95	95	127	14
15 KITCHEN VENT	2001	1,631		20	82	82	96	15
16 BOILER REPAIRS	2001	2,831		20	142	142	284	16
17 COOLER COMPRESSOR	2001	946		20	47	47	63	17
18 A/C UNITS FOR COOLER	2001	1,000		20	100	100	150	18
19 INSTALL NEW BOILER	2002	4,146		20	380	380	380	19
20 HOT WATER HEATER	2002	1,958		20	14	14	14	20
21 CONDENSER	2002	2,189		20	109	109	109	21
22 INSTALL WIRE	2002	850		20	78	78	78	22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30 31								30
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34
34 TOTAL (filles I tillu 33)		D 4,3/1,123	D 00,012		9 01,703	D 41,094	333,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26 27								26 27
28								28
29								29
30								30
31								31
32								32
33				1				33
34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3		4	5	6	7	8		9	T
		Year			Current Book	Life	Straight Line			cumulated	
	Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	De	epreciation	
	Totals from Page 12C, Carried Forward		\$	2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$	553,239	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20 21											20 21
22											22
23											23
24											24
25											25
26									1		26
27											27
28											28
29											29
30											30
31											31
32			 								32
	TOTAL (lines 1 thru 33)		\$	2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$	553,239	33

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17								17
18								18
19	-							19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		0 251 125	(0.013		01.003	21.002	D ##3 530	33
34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	I See inst	3		4	5	6	7	8		9	1
		Year			Current Book	Life	Straight Line			ccumulated	
	Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	D	epreciation	
	Totals from Page 12E, Carried Forward		\$	2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$	553,239	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9			ļ								9
10											10 11
12											11
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26 27											26 27
28											28
29			1						1		29
30											30
31											31
32											32
33											33
	TOTAL (lines 1 thru 33)		\$	2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$	553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar,

	B. Building Depreciation-Including Fixed Equipment. (See inst	3	4	1	5	6		7		8	9	$\overline{}$
		Year		Cu	rrent Book	Life	St	traight Line			Accumulated	
	Improvement Type**	Constructed	Cost		preciation	in Years	D	epreciation	Α	djustments	Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 2,371,125	\$	60,012		\$		\$	21,892	\$ 553,239	1
2	•											2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10 11				+								10 11
12				+								12
13				+								13
14				+								14
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16												16
17												17
18												18
19												19
20												20
21												21
22 23				+								22
24				+								24
25				+								25
26				+								26
27				1								27
28												28
29												29
30												30
31												31
32												32
33	TOTAL (1) 1 (1) 22)		2 251 125		(0.013			01.002		21.002	##A AAA	33
34	TOTAL (lines 1 thru 33)		\$ 2,371,125	\$	60,012		\$	81,903	\$	21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
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12								12
13								13
14								14 15
16								16
17								17
18								18
19	-							19
20								20
21								21
22								22
23								23
24								24
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26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		0 251 125	(0.013		01.003	21.002	D ##3 530	33
34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17								17
18								18
19	-							19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		0 251 125	(0.013		01.003	21.002	D ##3 530	33
34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	$\overline{1}$
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15 16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33 34 TOTAL (lines 1 thru 33)		\$ 2,371,125	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34
54 [TOTAL (IIIes I tillu 55)		JD 2,3/1,125	 \$ 60,012		81,903	 \$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	o nearest donar.	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		\$ 2,371,12	\$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14 15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32 33						-		33
34 TOTAL (lines 1 thru 33)		\$ 2,371,12	5 \$ 60,012		\$ 81,903	\$ 21,892	\$ 553,239	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	EOD OHE HEE ONLY	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1996		\$ 2,209,6	43 \$ 56,658		\$ 73,655		\$ 515,585	4
5					, , , ,			-			5
6											6
7											7
8											8
	Impr	ovement Type**									
9											9
10											10
11											11
12											12
13											13
14											14
15											15 16
16 17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											32
33											33
34							1				34
35											35
36											36
- 0				1		i	I	1			

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ANNA HENRY NSG & REHAB CTR XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53 54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,209,643	\$ 56,658		\$ 73,655	\$ 16,997	\$ 515,585	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Report Period Beginning:

Ending:

01/01/02

12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 395,282	\$ 36,631	\$ 39,529	\$ 2,898	10	\$ 263,383	71
72	Current Year Purchases	2,640	528	137	(391)	10	137	72
73	Fully Depreciated Assets	765				10	765	73
74								74
75	TOTALS	\$ 398,687	\$ 37,159	\$ 39,666	\$ 2,507		\$ 264,285	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		1990 FORD F350 VAN	1997	\$ 5,434	\$ 313	\$	\$ (313)	5	\$ 5,434	76
77										77
78										78
79										79
80	TOTALS			\$ 5,434	\$ 313	\$	\$ (313)		\$ 5,434	80

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount]
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,912,519	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,484	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,569	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,086	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 822,958	85]

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

21 TOTAL

** This amount plus any amortization of lease

expense must agree with page 4, line 34.

Faci	lity Name & I	D Number	ANNA HENRY NSC	G & REHAB CTF	R	#	0041483	F	Report Period I	Beginning:	01/01/02	Ending:	12/31/02
XII.	 Name of I Does the I 	nd Fixed Equip Party Holding L	ment (See instructions.) ease: N/A real estate taxes in addi		ount shown below o]NO					
		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount		5 Total Years of Lease	6 Total Ye Renewal O					
4	Original Building: Additions			\$			of Ecast	Kenewar O	3 4		ve dates of curren	_	ient:
	RESUN MO	BILE OFFICE I	LEASING		22,457 4,429				5 6	11 Dont to	he noid in future	voors under th	ha aummant
	TOTAL	A		S	26,886				7		be paid in future greement:	years under ti	ie current
	This amo	unt was calculat ngth of the lease	tization of lease expense ted by dividing the total		ortized		*			Fiscal You 12 13 14	/2003 /2004 /2005	Annual Re \$ \$ \$ \$	nt
	15. Is Mova	ble equipment r	nnsportation and Fixed ental included in buildi able equipment: \$	Equipment. (See ng rental?	instructions.) Description:	SEE A	YES X ATTACHED Attach a schedul		e breakdown of	movable equip	ment)		
	C. Vehicle Re	ental (See instru	ctions.)			•							
	1 Use		2 Model Year and Make		3 thly Lease ayment		4 Rental Expense for this Period			* If the	re is an option to	buy the building	ng,
17				\$		\$		17		-	e provide comple	te details on att	ached
18						_		18		sched	ule.		

21

Report Period Beginning:

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12/31/02 01/01/02 Ending:

XIII. I	EXPENSES	RELATING TO N	NURSE AIDE	TRAINING PRO	GRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are tra	ined in another fac	ility p	rogram, attach a schedule listing	the facility name, a	ddress and cost pe	r aide trained in that facility.)	
1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES	2.	CLASSROOM PORTION:		3.	CLINICAL PORTION:	<u></u>
PERIOD?	X NO		IN-HOUSE PROGRAM			IN-HOUSE PROGRAM	
If "yes", please complete the remainder			IN OTHER FACILITY			IN OTHER FACILITY	
of this schedule. If "no", provide an explanation as to why this training was			COMMUNITY COLLEGE			HOURS PER AIDE	
not necessary.			HOURS PER AIDE				

B. EXPENSES

ALLOCATION OF COSTS (d)

		Fa	acility		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
	Classroom Wages (a)				
	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\	,		
)		

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides. SEE ACCOUNTANTS' COMPILATION REPORT

0041483 Report Period Beginning:

01/01/02

Ending: 12

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

2 5 Schedule V **Outside Practitioner Supplies** Staff (Actual or) **Total Units** Service Line & Column Units of Cost **Total Cost** (other than consultant) Reference Allocated) (Column 2 + 4)(Col. 3 + 5 + 6)Service Units Cost **Licensed Occupational Therapist** 39 - 03 12,335 12,335 hrs Licensed Speech and Language **Development Therapist** 39 - 03 5,229 hrs 5,229 **Licensed Recreational Therapist** hrs **Licensed Physical Therapist** 39 - 03 24,080 hrs 24,080 Physician Care visits **Dental Care** visits Work Related Program hrs Habilitation hrs 8 # of Pharmacy 39 - 02 prescrpts 6,987 6,987 **Psychological Services** (Evaluation and Diagnosis/ **Behavior Modification)** hrs 10 **Academic Education** hrs **Exceptional Care Program** 12 13 Other (specify): See Supplemental 1,509 1,509 13 TOTAL 41,644 8,496 50,140

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

ANNA HENRY NSG & REHAB CTR Facility Name & ID Number

Report Period Beginning: (last day of reporting year) 12/31/02 As of

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	This report must be completed even	11 11n	anciai stateme			Т
		_	perating	2 After Consolidation*		
	A. Current Assets		perating		onsondation	
1	Cash on Hand and in Banks	S	26,115	\$	28,132	1
2	Cash-Patient Deposits	J	25,291	J)	25,291	2
	Accounts & Short-Term Notes Receivable-		23,291		23,291	
2			229 540		229 540	2
3	Patients (less allowance)		238,540		238,540	3
	Supply Inventory (priced at Short-Term Investments					
5			102 515		102 515	5
6	Prepaid Insurance		103,517		103,517	6
7	Other Prepaid Expenses				15.010	7
8	Accounts Receivable (owners or related parties)				17,018	8
9	Other(specify): See Supplemental Schedule					9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	393,463	\$	412,498	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land				137,273	13
14	Buildings, at Historical Cost				2,209,643	14
15	Leasehold Improvements, at Historical Cost		118,562		118,562	15
16	Equipment, at Historical Cost		101,684		426,654	16
17	Accumulated Depreciation (book methods)		(103,143)		(807,856)	17
18	Deferred Charges					18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): See Supplemental Schedule	1				23
	TOTAL Long-Term Assets	1				
24	(sum of lines 11 thru 23)	\$	117,103	\$	2,084,276	24
	TOTAL ASSETS					
25	(sum of lines 10 and 24)	\$	510,566	\$	2,496,774	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities		perating	onsondation	
26	Accounts Payable	\$	960,301	\$ 960,300	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		25,291	25,291	28
29	Short-Term Notes Payable		197,982	197,982	29
30	Accrued Salaries Payable		101,517	101,517	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		9,972	9,972	31
32	Accrued Real Estate Taxes(Sch.IX-B)		23,000	23,000	32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	See Supplemental Schedule		2,013,072	3,284,983	36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	3,331,135	\$ 4,603,045	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable			885,081	40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	See Supplemental Schedule				43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$ 885,081	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	3,331,135	\$ 5,488,126	46
47	TOTAL EQUITY(page 18, line 24)	\$	(2,820,569)	\$ (2,991,352)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	510,566	\$ 2,496,774	48

16 Other (describe)

18 19

20

B. Transfers (Itemize):

23 TOTAL Transfers (sum of lines 18-22)

17 TOTAL Additions (deductions) (sum of lines 7-16)

24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)

0041483

Report Period Beginning: 01/01/02

Page 18 12/31/02

Ending:

XVI. STATEMENT OF CHANGES IN EQUITY **Total** Balance at Beginning of Year, as Previously Reported (1,999,382)Restatements (describe): 2 3 3 4 4 5 Balance at Beginning of Year, as Restated (sum of lines 1-5) (1,999,382)6 A. Additions (deductions): 7 NET Income (Loss) (from page 19, line 43) (821,187) Aguisitions of Pooled Companies 8 Proceeds from Sale of Stock 9 10 Stock Options Exercised 10 11 11 Contributions and Grants 12 12 Expenditures for Specific Purposes 13 Dividends Paid or Other Distributions to Owners 13 14 14 Donated Property, Plant, and Equipment 15 Other (describe) 15

* This must agree with page 17, line 47.

16 17

18

19

20 21 22

23 24

(821,187)

(2,820,569)

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 1,859,260	1
2	Discounts and Allowances for all Levels	31,625	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,890,885	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,070	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,070	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	86	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,302	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,388	23
	D. Non-Operating Revenue		
	Contributions		24
	Interest and Other Investment Income***	13	25
26		\$ 13	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
	See Supplemental Schedule	1,998	28
28a	1000		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,998	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,918,354	30

	o agamet expense	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	576,201	31
32	Health Care	988,158	32
33	General Administration	858,599	33
	B. Capital Expense		_
34	Ownership	202,237	34
	C. Ancillary Expense		
35	Special Cost Centers	51,931	35
36	Provider Participation Fee	62,415	36
	D. Other Expenses (specify):		
37	• • • • • • • • • • • • • • • • • • • •		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,739,541	40
41	Income before Income Taxes (line 30 minus line 40)**	(821,187)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (821,187)	43

- * This must agree with page 4, line 45, column 4.
- ** Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.
- *** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

ANNA HENRY NSG & REHAB CTR

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

Facility Name & ID Number

· · · · ·	rung perroun,		
1	2**	3	4

	-	_	•	-				
	# of Hrs.	# of Hrs.	Reporting Period	Average				Nı
	Actually	Paid and	Total Salaries,	Hourly				0
	Worked	Accrued	Wages	Wage				P
1 Director of Nursing	790	790	Wages \$ 14,789	\$ 18.72	1	1		Ac
2 Assistant Director of Nursing	827	827	11,314	13.68	2	35	Dietary Consultant	MO
3 Registered Nurses	9,934	9,934	190,691	19.20	3	36	Medical Director	MO
4 Licensed Practical Nurses	16,453	16,453	241,036	14.65	4	37	Medical Records Consultant	MO
5 Nurse Aides & Orderlies	36,485	36,485	327,976	8.99	5	38	Nurse Consultant	
6 Nurse Aide Trainees					6	39	Pharmacist Consultant	MO
7 Licensed Therapist					7		Physical Therapy Consultant	
8 Rehab/Therapy Aides					8	41	Occupational Therapy Consultant	t
9 Activity Director	1,827	1,827	18,070	9.89	9	42	Respiratory Therapy Consultant	
10 Activity Assistants	3,409	3,409	19,728	5.79	10	43	Speech Therapy Consultant	
11 Social Service Workers	4,056	4,056	35,317	8.71	11	44	Activity Consultant	
12 Dietician					12	45	Social Service Consultant	
13 Food Service Supervisor					13	46	Other(specify)	
14 Head Cook					14	47	PSYCHO SOCIAL	
15 Cook Helpers/Assistants	18,347	18,347	112,178	6.11	15	48		
16 Dishwashers					16			
17 Maintenance Workers	4,840	4,840	33,293	6.88	17	49	TOTAL (lines 35 - 48)	
18 Housekeepers	8,109	8,109	41,824	5.16	18	<u></u>		
19 Laundry	8,436	8,436	51,526	6.11	19	1		
20 Administrator	2,080	2,080	55,877	26.86	20	1		
21 Assistant Administrator					21	C. 0	CONTRACT NURSES	
22 Other Administrative					22			
23 Office Manager					23			Ni
24 Clerical	5,153	5,153	56,741	11.01	24			0
25 Vocational Instruction					25			P
26 Academic Instruction					26			A
27 Medical Director					27	50	Registered Nurses	
28 Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29 Resident Services Coordinator	r				29	52	Nurse Aides	
30 Habilitation Aides (DD Homes	s)				30			
31 Medical Records	2,026	2,026	27,942	13.79	31	53	TOTAL (lines 50 - 52)	
32 Other Health Care(specify)	ŕ		ĺ		32	1		
33 Other(specify) See Supplement	ental				33	1		
34 TOTAL (lines 1 - 33)	122,771	122,771	\$ 1,238,302 *	\$ 10.09	34	SEE ACC	COUNTANTS' COMPILATION RI	EPORT

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	MONTHLY	\$ 4,358	01-03	35
36	Medical Director	MONTHLY	7,650	09-03	36
37	Medical Records Consultant	MONTHLY	2,774	10-03	37
38	Nurse Consultant	17	533	10-03	38
39	Pharmacist Consultant	MONTHLY	1,500	10-03	39
40	Physical Therapy Consultant	54	3,638	10a-03	40
41	Occupational Therapy Consultant	53	3,396	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	57	3,523	10a-03	43
44	Activity Consultant	52	2,579	11-03	44
45	Social Service Consultant	66	4,195	12-03	45
46	Other(specify)				46
47	PSYCHO SOCIAL	10	630	12-03	47
48					48
49	TOTAL (lines 35 - 48)	309	\$ 34,776		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	104	\$ 4,052	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	366	10,249	10-03	52
			_		
53	TOTAL (lines 50 - 52)	470	\$ 14,301		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

STATE	OF	ILL	IN()I(

IS Page 21 Facility Name & ID Number ANNA HENRY NSG & REHAB CTR # 0041483 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

A. Administrative Salaries		Ownership		D. Employee Benefits and Payroll T	l'axes			F. Dues, Fees, Subscriptions and Promotion		
Name	Function	%	Amount	Description			Amount	Description	Am	nount
MARCELLE HOEHN	ADMINISTRATOR	0	\$ 55,87	*		\$	50,693	IDPH License Fee	\$	
				Unemployment Compensation Insu	rance		19,794	Advertising: Employee Recruitment		2,442
				FICA Taxes			94,727	Health Care Worker Background Check		
	_			Employee Health Insurance			18,806	(Indicate # of checks performed 9)		109
				Employee Meals			9,822	DUES		14,467
				Illinois Municipal Retirement Fund	l (IMRF)*			LICENSE		1,000
				EE BENEFIT PLAN			1,074	ADVERTISING		994
TOTAL (agree to Schedule V, lin	ne 17, col. 1)			EMPLOYEE BENEFIT			25,874	YELLOW PAGE ADVERTISING		1,603
(List each licensed administrator	separately.)		\$ 55,87					ALLOC HMA DUES		159
B. Administrative - Other										
								Less: Public Relations Expense		
Description			Amount					Non-allowable advertising	-	(994)
HOME OFFICE-ADMINISTRA	TIVE		\$ 190,00					Yellow page advertising		(1,603)
MANAGEMENT FEE- M-SUIS	SA		38,64							
MANAGEMENT FEE- E. ROTI	HNER		38,64	TOTAL (agree to Schedule V,		\$	220,789	TOTAL (agree to Sch. V,	\$	18,176
MANAGEMENT FEE- D. ARYI	EH		6,72	line 22, col.8)				line 20, col. 8)		
TOTAL (agree to Schedule V, lin	ne 17, col. 3)		\$ 274,00	E. Schedule of Non-Cash Compensa	ation Paid			G. Schedule of Travel and Seminar**		•
(Attach a copy of any manageme	nt service agreement)			to Owners or Employees						
C. Professional Services	,			- '				Description	Am	nount
Vendor/Payee	Type		Amount	Description	Line#		Amount	•		
PERSONNEL PLANNER	UNEMPLOYME	NT	\$ 1,99			\$		Out-of-State Travel	\$	
FR & R	ACCOUNTING		10,00							
DUANE MORRIS	LEGAL	_	31,04						-	
BKD	ACCOUNTING	_	82					In-State Travel	-	
THRESHOLD	DATA PROCESS	ING	2,2						-	
KRONOS	DATA PROCESS		10				-		-	
ALEXANDER	DATA PROCESS		18			_			1	
DATAMAX	DATA PROCESS					_		Seminar Expense	1	1,587
FRANKEL, RUBIN, BOND	LEGAL		4.5			_		ALLOC HMA	1	285
LEVY, LEVY STIPES	LEGAL		94						-	
	LLGIL	_				_	_			
		_				_		Entertainment Expense		
TOTAL (agree to Schedule V, lin	ne 19. column 3)			TOTAL		\$		(agree to Sch. V,		
(If total legal fees exceed \$2500 a			\$ 47,87			—		TOTAL line 24, col. 8)		1,872

* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.) 3 5 6 8 10 11 12 13 1 2 4 Month & Year **Amount of Expense Amortized Per Year Improvement** Useful **Improvement Total Cost Was Made** FY1999 FY2000 FY2002 FY2003 FY2004 FY2005 FY2006 FY2007 Type Life FY2001 \$ \$ 2 3 5 6 8 9 10 11 12 13 14 15 16 17 18 19 20 **TOTALS**